STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396003	A. BLDG: 00 B. WING:	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MONROEVILLE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **076502**	**885 MACBETH DR** **MONROEVILLE, PA 15146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance, and Abbreviated Survey in response to two complaints, completed on April 20, 2023, it was determined that Monroeville Skilled Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0554 SS=E		F 0554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0554 SS=E	Continued from page 1 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 0554	Facility failed to appropriately assess and obtain physician orders for residents to safely self administer medications for three of six residents. R57, R220, and R221 notifications were completed, no adverse outcome, medications administered/removed from bedside. R57 was monitored and no new orders for medication at bedside. R220 Resident was assessed for ability to keep eye drops at bedside. MD notified and order obtained for self administration. R221 No indication was determined for use of the eye drops from home, family took medication home. All other like-residents have the potential to be affected. To prevent this from occurring to all other residents in the building, the facility will complete an audit of all residents to ensure medications are not located at the bedside. For those residents that are found to self administer, a clinical evaluation will be conducted to determine if the resident is able to self administer	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

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F 0554 SS=E	Continued from page 2	F 0554	medications and an order will be obtained for medication self administration. Education will be provided by DON/designee to licensed nursing staff regarding the medication self administration policy. Ongoing audits of a sample of 10 rooms for medications at bedside will be conducted by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and monthly until compliance is achieved.	

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F 0554 SS=E	Continued from page 3 Based on a review of facility policy, observations, resident record reviews, resident interviews, and staff interviews it was determined the facility failed to appropriately assess and obtain physician orders for residents to safely self -administer medications for three of six residents (Residents R57, R220, and R221). Findings include: The facility policy titled "Medications: Self Administration" last reviewed on 2/16/23, informed patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the the patient's functionality and health condition. If it is determined that the patient is able to self-administer: a physician/advanced provider (APP) order is required, self-administration and medication storage must be care planned, patient must be provided with with a secure, locked area to maintain medications, patient must be instructed in self-administration.	F 0554		

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F 0554 SS=E	Continued from page 4 A review of the Admission Record indicated Resident R57 admitted to the facility on 2/11/22. A review of Resident R57's Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 3/23/23, indicated diagnoses of diabetes (too much sugar in the blood), depression, and hyperlipidemia (high levels of fat in the blood). A review of Resident R57's physician orders on 4/17/23, indicated the following medications of aspirin (fever/pain reducer), Eliquis (a blood thinner/anticoagulant), Lasix (furosemide - a diuretic for fluid retention), Glipizide (used to lower blood sugar along with diet and exercise) Neurontin (used to treat seizures), Lexapro (used to treat Depression), Pepcid (used to treat stomach acid), and potassium chloride (used as a supplement). A review of Resident R57's April 2023, Medication Administration Record (MAR) indicated the medications were still active and marked as given.	F 0554		

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F 0554 SS=E	Continued from page 5 During an interview and observation on 4/17/23, at 9:51 a.m., Resident R57 was sitting at bedside, the medication cup was observed sitting on the bedside table beside the bed with 8 pills inside. Resident R57 stated that they were his and the nurse had left them on the table. Review of the clinical record failed to reveal an assessment done for self-administration of medications. Review of the physician's orders failed to include an order for self-administration. During an interview on 4/17/23, at 9:51 a.m. Registered Nurse (RN) Employee E14 confirmed the medications were left at the bedside. During an interview on 4/17/23, at 9:53 a.m. Licensed Practical Nurse (LPN) Employee E6 stated she left the medications on the bedside table because "Resident R57's roommate was refusing his	F 0554		

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F 0554 SS=E	Continued from page 6 medications and she was busy notifying her supervisor that had occurred." During an interview on 4/17/23, at 9:55 a.m. LPN Employee E6 confirmed the facility failed to appropriately assess and obtain physician orders for residents to safely self -administer medications. A review of Resident R220's record revealed the resident was admitted to the facility on 4/14/23. Diagnoses included seizures, atrial fibrillation (irregular heartbeat), depression, and alcohol abuse withdrawal. A review of Resident R220's physician note dated 4/17/23, indicated a past medical history to include glaucoma. A review of Resident R220's physician orders dated 4/20/23, included Brimonidine Tartrate 0.02% drops for glaucoma (increased eye pressure causing gradual loss of sight) to be administered one drop	F 0554		

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F 0554 SS=E	Continued from page 7 both eyes for three times a day. A review of Resident R220's care plan dated 4/14/23, included the resident has impaired vision evidenced by glaucoma. Interventions included to keep frequently used items within reach, eye examinations, activities of daily living assistance as needed, and report eye pain or decrease in vision. A review of Resident R220's medication administration record for April, 2023, documented the medication Brimonidine Tartrate 0.02% was administered by staff on 4/14/23, at 4:00 p.m., 4/15/23, at 8:00 a.m., 12:00 p.m. and 4:00 p.m., and on 4/16/23, at 8:00 a.m., 12:00 p.m. and 4:00 p.m. During an observation on 4/17/23, at 11:10 a.m., Resident R220 had a bottle of Brimonidine Tartrate 0.02% drops on the bedside tray table. During an interview on 4/17/23, at 11: 12 a.m. Resident R220 reported self - administering the eye	F 0554		

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F 0554 SS=E	Continued from page 8 drops. During an interview on 4/17/23, at 11:13 a.m., Licensed Practical Nurse Employee E13 confirmed the facility failed to obtain a physician order for Resident R220 to self - administer medication. A review of Resident R221's record revealed the resident was admitted to the facility on 4/13/23. Diagnoses included diabetes, anemia, hypertension (high blood pressure), shortness of breath, hypothyroidism (underactive thyroid resulting in fatigue, weight gain, and intolerance to cold temperatures) and hyperlipidemia (high cholesterol). During an observation on 4/17/23, at 11:15 a.m. Resident R221 had a bottle of Sooth XL eye drops on the bedside tray table. A review of Resident R221's physician orders dated 4/20/23, did not include the over the counter medication of Soothe XL eye drops.	F 0554		

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F 0554 SS=E	Continued from page 9 A review of Resident R221's medication administration record for April, 2023, did not include the over the counter medication of Soothe XL eye drops. A review of Resident R221's care plan dated 4/14/23, did not include the resident was assessed to self - administer medications. During an interview on 4/17/23, at 11: 15 a.m., Resident R221 reported self - administering the eye drops. During an interview on 4/17/23, at 11:18 a.m., Licensed Practical Nurse Employee E13 confirmed the facility failed to appropriately assess and obtain physician orders for residents to safely self -administer medications. 28 Pa. Code: 211.9(d) Pharmacy Services	F 0554		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 10 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Facility failed to develop and implement comprehensive care plans for 2 of 16 residents. R217 and R34 care plans were updated to include the cited elements. No residents were adversely affected as an outcome of this failure. All other like-residents have the potential to be affected. To prevent this from occurring to all other residents in the building, the facility will complete an audit of all residents to ensure a comprehensive care plan is in place. Education will be provided by DON/designee to licensed nursing staff regarding the person centered care plan policy. Ongoing audits related to care planning past medical history will be conducted for a sample of 10 residents by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and monthly until compliance is achieved.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

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F 0656 SS=D	Continued from page 11 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: [illegible]	F 0656		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 12 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Facility failed to update a care plan for one of eight residents to accurately reflect the care of the suprapubic catheter of the resident. No residents were adversely affected as an outcome of this failure. The order was updated for the care of the suprapubic catheter for R47. All other like-residents have the potential to be affected. To prevent this from occurring to all other residents in the building, the facility will complete an audit of all residents to ensure a comprehensive care plan is in place. Education will be provided by DON/designee to licensed nursing staff regarding the person centered care plan policy. Ongoing audits related to comprehensive care plans will be conducted by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and monthly until compliance is achieved.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 0657 SS=D	Continued from page 13 [illegible]	F 0657		
F 0684 SS=G		F 0684		

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F 0684 SS=G	Continued from page 14 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Facility failed to make certain that residents were provided appropriate treatment and services to maintain bowel function that resulted in actual harm of a severe fecal impaction and required hospitalization for one of three residents, notify the physician in a timely manner of a residents change in medical condition for two of six residents. One resident was affected by this failure causing a hospitalization. R6 and R50 provider was consulted and reviewed and updated parameters for sliding scale, and no adverse outcomes were noted. R34 returned from the hospital and has had no further incident. To prevent this from occurring to all other residents in the building, the facility will complete an audit of all residents to ensure that bowel function is being maintained as well as notification to a physician regarding change in medical condition is complete.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

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F 0684 SS=G	Continued from page 15	F 0684	A directed inservice will be conducted by Affinity on 5/15 and recorded for future audiences. It will be presented to nurse aides and licensed nursing staff regarding the importance of monitoring bowel incontinence as well as diabetes management and following sliding scale orders. Ongoing audits will be conducted for followup on residents who have not had a BM in 3 days and for residents who have an abnormal glucose reading according to sliding scale by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and then monthly until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396003	A. BLDG: __00_____ B. WING: _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MONROEVILLE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 076502	885 MACBETH DR MONROEVILLE, PA 15146

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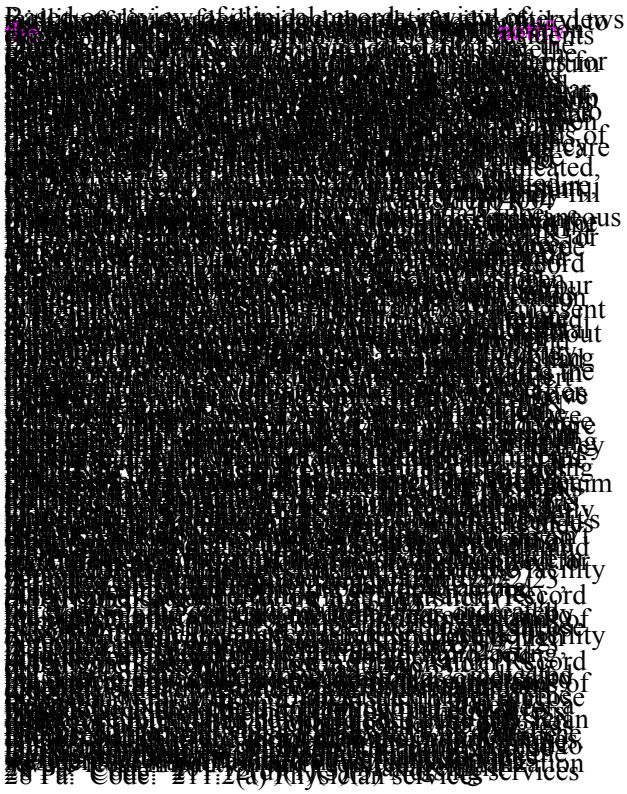
F 0684 SS=G	Continued from page 16 	F 0684		
F 0689 SS=E		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=E	Continued from page 17 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Facility failed to assess residents for smoking safety for three of three residents. No residents were adversely affected as an outcome of this failure. R24, R52, and R110 received a smoking assessment as well as education regarding non-smoking facility. No adverse outcomes related to the incident were noted. All other like-residents have the potential to be affected. The non-smoking status of the facility is conveyed prior to and on admission, and cessation interventions are offered by the providers as warranted. To prevent this from occurring to all residents in the building, the facility conducted an audit of all like residents to assess for risk of smoking during admission. A facility non-smoking assessment was complete on all like-residents. Education will be provided by DON/designee to the facility employees regarding the smoking policy. Ongoing audits related to	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0689 SS=E	Continued from page 18	F 0689	resident compliance with the smoking policy will be conducted on a sample of all residents assessed to be at high risk for smoking by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and then monthly until compliance is achieved.	

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F 0689 SS=E	Continued from page 19 Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to assess residents for smoking safety for three of three residents (Resident R24, R52 and R110). Findings include: Review of facility provided documents on 4/17/23, indicated the facility has zero smokers in the building and is a smoke free campus. A review of the facility "Smoking Policy" dated 2/16/23, indicated the facility is a smoke-free community and smoking in any form through the use of tobacco products (pipes, cigars, and cigarettes) or "vaping" with electronic cigarettes is prohibited. For Centers that allow smoking - smoking (including the use of e-cigarettes) will be permitted in designated areas only. Residents will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely and, if necessary, will be supervised.	F 0689		

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F 0689 SS=E	Continued from page 20 Review of Admission Record indicated Resident R24 was admitted to the facility on 2/7/23. Review of Resident R24's Minimum Data Set (MDS-a periodic assessment of care needs) dated 2/14/23, indicated the diagnoses of thyroid disorder (dysfunction of the butterfly-shaped gland at the base of the neck), depression, and chronic pain and Section J1300 indicated R24 was not an active smoker. Review of Resident R24's clinical record failed to indicate a smoking assessment was completed. Review of Resident R24's physician orders failed to indicate an order for smoking privileges. Review of Resident R24's care plan failed to indicate a problem, goal, or interventions relating to smoking. Observation on 4/19/23, at `12:45 p.m. Resident	F 0689		

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F 0689 SS=E	Continued from page 21 R24 was observed on the front patio in a wheelchair, with a lit cigarette in her mouth and hand. On 4/19/23, at 12:49 p.m. Nursing Home Administrator confirmed Resident R24 was smoking and had attempted to hide it by cupping it up against the wheelchair in her hand. When asked to lift the towel that was on her lap to ensure the cigarette was not burning the resident, in an attempt to hide it, Resident R24 gave permission and lifted the towel revealing a pack of Newport cigarettes. Review of Admission Record indicated Resident R52 was admitted to the facility on 1/27/23. Review of Resident R52's MDS dated 2/3/23, indicated the diagnoses of high blood pressure, depression and convulsions (sudden, violent, irregular movement of a limb or the entire body caused by a brain disorder) and Section J1300 indicated R52 was not an active smoker.	F 0689		

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F 0689 SS=E	Continued from page 22 Review of Resident R52's clinical record failed to indicate a smoking assessment was completed. Review of Resident R52's physician orders failed to indicate an order for smoking privileges. Review of Resident R52's care plan failed to indicate a problem, goal, or interventions relating to smoking. On 4/19/23, at 1:00 p.m. interview with Receptionist Employee E16 indicated the residents must present a slip from their nursing unit in order to go on leave outside of the facility and Resident R52 goes out daily. When asked if they knew the facility was smoke free, she indicated "the residents know". Review of the Admission Record indicated Resident R110 was admitted to the facility on 3/6/23. Review of Resident R110's MDS dated 3/18/23, indicated the diagnoses of liver cancer, spinal stenosis (a narrowing of the spinal canal), and	F 0689		

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F 0689 SS=E	Continued from page 23 transient Ischemic attacks (TIA's- a brief, stroke like attack). Review of Resident R110's clinical record failed to indicate a smoking assessment was completed. Review of Resident R110's physician orders failed to indicate an order for smoking privileges. Review of Resident R110's care plan failed to indicate a problem, goal, or interventions relating to smoking. Observation on 4/19/23, at `12:45 p.m. Resident R110 was observed on the front patio in a wheelchair, with a lit cigarette in his right hand and several cigarette butts on the ground around his wheelchair. On 4/19/23, at 12:49 p.m. Nursing Home Administrator confirmed Resident R110 was smoking and stayed with residents to intervene.	F 0689		

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F 0689 SS=E	Continued from page 24 On 4/19/23, at 1:00 p.m. interview with Receptionist Employee E16 indicated that day was the first time Resident R24 brought a slip to go outside, but Resident R52 and R110 bring slips since the beginning and go out daily to smoke on the patio out front. During an interview on 4/19/23, at 2:00 p.m. the Nursing Home Administrator confirmed they were unaware of Residents R24, R52, and R110 smoking on the campus and the facility failed to complete a smoking safety assessment. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.11(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0689		

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F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 0690	Facility failed to obtain a physician order for care of a suprapubic catheter for one of five residents. The order for R47 was updated to include care for the suprapubic catheter. No residents were adversely affected as an outcome of this failure. All other like-residents have the potential to be affected. To prevent this from occurring to all residents in the building, the facility conducted an audit of all like-residents to ensure orders were in place regarding the care of a suprapubic catheter. Education will be provided by DON/designee to licensed nursing staff regarding the policy and care of urinary catheters. Ongoing audits related to orders for care of a suprapubic catheter will be conducted by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and then monthly until compliance is achieved.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

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F 0690 SS=D	Continued from page 26 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to obtain a physician order for care of a supra-pubic catheter (a hollow flexible tube that is used to drain urine from the bladder that is inserted into the bladder through a cut in the abdomen) for one of five residents (Resident R47). Findings include: A review of the facility policy "Catheter: Urinary - Justification for Use" reviewed 9/9/22 and 2/6/23, failed to address supra-pubic catheters. A review of the clinical record indicated Resident R47 was admitted to the facility on 11/1/22, with diagnoses that included high blood pressure, neurogenic dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and diabetes. A review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 4/4/23,	F 0690		

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F 0690 SS=D	Continued from page 27 indicated the diagnoses remain current. A review of the physician orders dated 2/15/23, indicated to maintain suprapubic catheter. Further review of the physician orders failed to reveal an order for care of the supra-pubic catheter. A review of the care plan revised on 2/16/23, indicated catheter care every shift. During an interview on 4/19/23, the Director of Nursing confirmed the facility failed to have an order for the care of the suprapubic catheter for Resident R47. 28 Pa. Code: 201.18(b)(1)(e)(1)Management. 28 Pa. Code: 201.20(c)Staff development. 28 Pa. Code: 211.10(d)Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5)Nursing services.	F 0690		

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F 0698 SS=E		F 0698		

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F 0698 SS=E	Continued from page 29 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	Facility failed to maintain ongoing communication with the dialysis center for three of five residents reviewed and failed to reveal a physician order for care of the dialysis catheter for one of two residents. No residents were adversely affected as an outcome of this failure. The orders for the cited residents have been updated. All other like-residents have the potential to be affected. To prevent this from occurring to all other residents in the building, the facility conducted an audit of all like-residents to ensure that communication is complete and orders were in place regarding the care of the dialysis catheter. Education will be provided by DON/designee to licensed nursing staff regarding the policy, dialysis: hemodialysis provided by a certified dialysis center. Ongoing audits related to orders for dialysis and care of the dialysis catheter and communication with dialysis centers	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/11/2023**

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F 0698 SS=E	Continued from page 30 Based on review of clinical records, staff interviews, and facility policies, the facility failed to [illegible] 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0698	will be conducted by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and then monthly until compliance is achieved.	
F 0699 SS=D		F 0699		

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F 0699 SS=D	Continued from page 31 483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by:	F 0699	Facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents. No residents were adversely affected as an outcome of this failure. A trauma assessment was completed for R217 and their plan of care was updated accordingly. All other like-residents have the potential to be affected. To prevent this from occurring to all other residents in the building, the facility conducted an audit of all like-residents to ensure that a trauma informed assessment was complete. Education will be provided by DON/designee to licensed nursing staff regarding the trauma informed care assessments. Ongoing audits of residents with a diagnosis of PTSD for completion of trauma informed assessments and care plan will be conducted by DON/designee weekly x 4 weeks, then weekly x 2 weeks, and then monthly thereafter until compliance is achieved.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/10/2023**

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MONROEVILLE SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 076502	885 MACBETH DR MONROEVILLE, PA 15146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0699 SS=D	Continued from page 32 Based on review of facility policy, resident record review, resident interview, and staff interviews, it was determined to facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R217). Findings include: Review of facility policy titled "Assessments" last reviewed 2/16/23, informed the purpose is to determine the patient's social, functional, emotional, and cognitive status and history of trauma and /or post traumatic stress disorder (PTSD), and to develop an individualized Social Services plan of care. Practice standards included to communicate identified cognitive patterns, mood/recent experiences, adjustment, mental health, and trauma history to the interdisciplinary team. Review of Resident R217's record indicated the resident was admitted on 4/5/23. Diagnoses	F 0699		

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F 0699 SS=D	Continued from page 33 included post traumatic stress disorder (PTSD - a psychiatric disorders that may occur in persons that have witnessed a traumatic event causing intense, disturbing thoughts and feelings related to the experience), depression, paraplegia (paralysis of the lower body), and chronic pain. Review of physician orders dated 4/20/23, included Meditelehealth (technology enabled healthcare services) to evaluate and treat psychiatric and psychological health, monitor side effects related to the use of psychotropic medications of Quetiapine Fumarate (PTSD), Sertraline (depression), and Xanax (anxiety), pain evaluation every shift, Review of Resident R217's care plan dated 4/6/23, addressed chronic pain, and medication monitoring for adverse effects from antianxiety and antipsychotic medication use. The care plan did not address PTSD and depression. Review of Resident R217's assessments did not include a Trauma Informed Care Evaluation (a data	F 0699		

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F 0699 SS=D	Continued from page 34 collection tool that gathers information on traumatic events and aids in identifying and addressing the resident's needs). Review of Resident R217's Social Service Assessment dated 4/7/23, indicated a BIMS (Brief Interview for Mental Status, a screening tool to determine cognition) score of 15, indicating the resident is cognitively intact, is diagnosed with a mental illness, was assessed to have mild depression, and a Meditelecare referral was made. Review of Resident R217's progress notes revealed a Social Service note dated 4/7/23, indicating a referral was made to Meditelecare due to tearfulness [and] depressed. Review of Resident R217's Social Service progress note dated 4/11/23, indicated the resident was tearful at times. Review of Resident R217's evaluations revealed a Meditelecare evaluation conducted on 4/10/23. The	F 0699		

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F 0699 SS=D	Continued from page 35 report included a history of PTSD and included a description of the event that occurred. The plan of care included Meditelecare to follow for supportive therapy. During an interview on 4/20/23, at 12:48 p.m. Resident R217 reported having re-occuring memories and flashbacks [of the traumatic event] every day. The resident reported tearfulness and has "to let the tape play." The resident reported staff have observed the tearfulness. The resident also reported, prior to admission, receiving weekly counseling sessions for PTSD. During an interview on 4/20/23, at 1:00 p.m. Registered Nurse Employee E11 reported not knowing that Resident R217 suffered from PTSD not observed PTSD in the resident's care plan. During an interview on 4/20/23, at 11:45 a.m. the Director of Nursing confirmed the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause	F 0699		

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F 0699 SS=D	Continued from page 36 re-traumatization. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.	F 0699		

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P 0540	§ 201.19 Personnel policies and procedures. Personnel records shall be kept current and available for each employe and contain sufficient information to support placement in the position to which assigned. This REGULATION is not met as evidenced by:	P 0540	The two identified employees without physicals will have them completed by a provider. No residents were adversely affected, and all employees have the potential to be affected. To prevent this from occurring to other individuals, the facility will conduct an audit of hires from the past 4 months for completeness of the employee physical. Education will be provided to the HR director by NHA or designee. Ongoing audits related to pre-employment physicals for new hires will be conducted by the NHA or designee weekly x 4 weeks, and then monthly thereafter until compliance is achieved.	Completion Date: **05/29/2023** Status: **APPROVED** Date: **05/09/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0540	Continued from page 1 Based on review of employee personnel records and staff interview it was determined that the facility failed to maintain required information for two of five employee records (Employee E1 and E2). Findings include: A review of Licensed Practical Nurse (LPN) Employee E2's personnel file revealed the employee had a start date of 3/13/23. The file did not include a physical completed by a physician. A review of Certified Nurse Aide (NA) Employee E1's personnel file revealed the employee had a start date of 3/18/23. The file did not include a physical completed by a physician. During an interview on 4/19/23, at 2:30 p.m., the Director of Human Resources confirmed that the facility failed to maintain complete personnel records for two of five employees.	P 0540		
P 1600		P 1600		

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P 1600	Continued from page 2 § 209.8(b) Fire Drills. (b) A written report shall be maintained of each fire drill which includes date, time required for evacuation or relocation, number of residents evacuated or moved to another location and number of personnel participating in a fire drill. This REGULATION is not met as evidenced by:	P 1600	No residents were adversely affected by the identified gaps on the fire drill documentation forms. All residents have the potential to be affected. To prevent this from occurring during other fire drills, the facility will include documentation in future drills of the number of residents evacuated or moved to a fire safe location and the total time for the evacuation/relocation of residents. Education will be provided to the maintenance director by NHA or designee. Ongoing audits related to fire drill documentation will be conducted by the NHA or designee weekly x 4 weeks, and then monthly thereafter until compliance is achieved.	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/09/2023**

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P 1600	Continued from page 3 Based on review of the facility's Fire Drill Reports and staff interview, it was determined the facility failed to maintain written fire drill reports that recorded number of residents evacuated or moved to a fire safe location, and the total time for the evacuation/relocation of residents for 12 of 12 months (1/2022, 2/2022, 3/2022, 4/2022, 5/2022, 6/2022, 7/2022, 8/2022, 9/2022, 10/2022, 11/2022, 12/2022). Findings include: Review of the Fire Drill Reports dated 1/2022 through 12/2022, did not include documentation of the number of residents evacuated or moved to a fire safe location, and the total time for the evacuation/relocation of residents for the fire drills conducted during the months of 1 /2022, 2/2022, 3/2022, 4/2022, 5/2022, 6/2022, 7/2022, 8/2022, 9/2022, 10/2022, 11/2022, and 12/2022. During an interview on 4/20/23, at 10:09 a.m. the Maintenance Director Employee E17 confirmed the	P 1600		

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P 1600	Continued from page 4 Fire Drill Reports dated 1/2022 through 12/2022, did not record the number of residents evacuated or moved to a fire safe location, and the total time for the evacuation/relocation of residents as required.	P 1600		
P 2020		P 2020		

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P 2020	Continued from page 5 § 211.12(i) Nursing services. (i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 2020	No residents were adversely affected as an outcome of the HPPD on 2/12/2023. The cited date was reported timely to DOH via ERS. All residents have the potential to be affected. To prevent this from occurring, the RN supervisors will be educated by NHA or designee about notification escalations for call-offs and calculating HPPD. The facility also utilizes agency staff, pick up bonuses, overtime, holds on admission, accountability for attendance, and support from management staff to ensure adequate staff to provide resident care. The facility staffing committee that meets each weekday will continue to look ahead at the upcoming schedule to allow time to secure sufficient staff. Ongoing audits of HPPD will be conducted before and after each date by the NHA or designee weekly x 4 weeks, and then monthly thereafter until compliance is	Completion Date: **05/30/2023** Status: **APPROVED** Date: **05/10/2023**

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P 2020	Continued from page 6 Based on review of nursing care hours and staff interview, it was determined the facility failed to meet state minimum staffing levels that could affect resident health and safety for 1 of 21 days, on 2/12/23. Findings include: Review of the facility "Nursing Care Hours" form (schedule for Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides) for dates 2/12/23, indicated the facility failed to meet state required minimum of 2.70 hours of care Per Patient Day (PPD) on the following days: 2/12/23 - 2.51 hours During an interview on 4/18/23, at 9:50 a.m. the Nursing Home Administrator confirmed the review of Nursing Care Hours, and the facility failed to meet the state minimum staffing levels for resident care that could affect resident health and safety.	P 2020	achieved.	

Certified End Page

MONROEVILLE SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 076502

SURVEY EXIT DATE: 04/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY